VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 30, 2015

Mr. Steven Doe, Manager
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476-7637

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 26, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 06/10/2015
FORM APPROVED

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0197 | A. BUILDING: _____ B. WING _____ | C 05/26/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OUR LADY OF THE MEADOWS | 1 PINNACLE MEADOWS RICHFORD, VT 05476 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R100 | Initial Comments:<br><br>An unannounced onsite investigation into a self-reported incident was conducted by the Division of Licensing and Protection on 5/26/15. The following regulatory deficiency was identified: | R100 | | |
| R208 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.18 Reporting of Abuse, Neglect or Exploitation<br><br>5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the home failed to ensure that resident to resident altercations were reported as required for 6 of 6 residents reviewed (Residents #1, 2, 3, 4, 5 and #6). Findings include:<br><br>Per record review on 5/26/15, Resident #1 had a diagnosis of Alzheimer's, Depression, and was noted to have aggressive behaviors toward other residents. In reviewing the resident's progress notes, there were a number of incidents involving this resident pushing or hitting other residents at the home.<br><br>On 3/31/14, there was documentation stating that Resident #1 had pushed Resident #2, resulting in | R208 | PLEASE SEE ATTACHED<br><br>6/25/15 R208<br>POC accepted<br>Karen Campos RN | |

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/25/15

Division of Licensing and Protection

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|---|---|---|---|---|
| R208 | Continued From page 1<br><br>a fall with no injury. On 5/2/14, documentation stated that Resident #1 had pushed Resident # 3, and also pushed a dining room table into this same resident, also no injury noted. On 6/11/14, documentation stated that Resident #1 pushed Resident #3 so that they fell and hit their head. On 6/29/14, Resident #1 pushed Resident #4 so that they also fell and hit their head. On 9/10/14, it was documented that Resident #1 and Resident #5 grabbed each other's arms, and that Resident #1 then punched Resident #5 in the cheek. On 10/1/14, a progress note stated that Resident #1 stated that they had pushed Resident #2 so that they fell, and documentation in Resident #2's record showed that they were found sitting outside their room on the floor the evening of 9/30/14, and it was recorded as an unwitnessed fall by staff. An incident on 9/23/14 was documented as an attempt by Resident #1 to push Resident #6, however staff were able to intervene before the resident was actually pushed down.<br><br>Resident #1 was moved to a single room on 8/20/14, after multiple incidents of being aggressive to Resident #2, who at that time was their roommate. Staff described Resident #1 as "territorial", and physically aggressive at times with little warning. Per interview on 5/26/15 at 12:20 PM, the Registered Nurse stated that these incidents were not reported to the Licensing agency as there were no significant injuries to the victims of these altercations, even though there was a pattern of aggressive behavior. Per interview on 5/26/15, the home Manager confirmed that these incidents were not reported to the state licensing agency as required. | R208 | | |



S4b

Our Lady Of The Meadows
Plan of Correction
Residential Care Home State Survey
May 26, 2015

**R208**

5.18

**Action:** Resident #1 was relocated to a private room on 8/20/14. Staff closely monitored Resident #1. Medication intervention proved unsuccessful. Resident #1 was issued a Discharge Notice on 9/5/14. On 10/1/14, prior to discharge, Resident #1 died from natural causes.

**Measures:** Administrator and Nurse Manager developed a policy and procedures to provide on-going protocol for Abuse Prevention (Please see Attachment 1). The Nurse Manager will review the new Abuse Prevention Policy with all Nursing Staff. The Nursing Staff will review this new policy with all Direct Care Staff and Activity Staff to work collectively in maintaining an environment free from mental, verbal or physical abuse, neglect and exploitation. Additionally, the Nurse Manager will instruct all Nursing Staff to report to the licensing agency any and all resident-to-resident incidents of abuse to the licensing agency if the resident alleges abuse, sexual abuse, or is an injury requiring physician intervention results, or if there is a pattern of abusive behavior.

**Monitors:** Administrator and Nurse Manager will monitor this practice to insure that this deficiency does not occur again.

**Date Completed:** 06/30/2015

6/25/15
R208. POC accepted. Karen Campos RN

# abuse prohibition POLICY



## What we want to happen...

We will not tolerate any form of abuse, neglect, or exploitation.

## Why its important...

Staff must be skilled in working with confused residents so that challenging behavior is avoided whenever possible, and handled with dignity and compassion when it occurs.

## How to make it happen...

1. Maintain a ZERO tolerance for ANY form of abuse, neglect, or exploitation.
2. Maintain a work and living environment that is professional and free from threat of and/or occurrence of harassment, abuse (verbal, physical, mental, psychological, or sexual), neglect, corporal punishment, involuntary seclusion, or misappropriation of property.
3. Protect residents from abuse, neglect, or exploitation by anyone, including but not limited to: staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.
4. Provide a safe, comfortable, and homelike environment.
5. Promote an atmosphere of communication and sharing with residents and staff without fear of intimidation, retribution, or retaliation.
6. Promote staff understanding and appreciation of their unique position of trust with all residents and particularly the most vulnerable of residents.
7. Ensure that staff use caring, ethical, and professional behavior in all relationships with residents.

The Assisted Living Policy Manual
v.1.0


UNIVERSITY

# abuse prohibition POLICY (continued)



**Definitions**

**Abuse** — Any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, pain, or mental anguish.

**Mental Abuse** — The infliction of mental/emotional suffering. It includes, but is not limited to, humiliation, harassment, making demeaning statements, intimidation, threats of punishment or deprivation.

**Physical Abuse** — The infliction of physical pain or injury to a resident. It includes, but is not limited to, pushing, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment, or the misuse of physical or chemical restraints.

**Sexual Abuse** — Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

**Verbal Abuse** — The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

**Involuntary Separation or Seclusion** — Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short-term monitored separations from other residents are not considered involuntary seclusion. Monitored seclusion may be permitted, for a limited period of time, as a therapeutic intervention for agitatinn until professional staff can develop a plan of care to meet the resident's needs.

**Exploitation or Misappropriation of Resident Property** — The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Examples include theft of a resident's private television, false teeth, clothing, jewelry, money, using a resident's telephone, etc.

# abuse prohibition POLICY (continued)



**Neglect** — The failure to provide goods and services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment, rehabilitation, care, attention, food, clothing, shelter, supervision, or medical services by a caregiver. Neglect is also creating situations in which esteem is not fostered. This could include instances where competent resident's wishes are not honored, restricting contact with family, ignoring the resident's need for verbal and emotional contact.

**Vulnerable Adult** — Any person over 18 years of age suffering from physical or mental infirmity or dysfunction impairing the person's ability to care for or protect himself.

**Misuse of Restraints** — Chemical or physical control of a resident beyond the physician's orders or not in accordance with the resident's plan of care and acceptable medical practice. This includes a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms. This also includes any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily that restricts freedom of movement or normal access to one's body and is used for discipline or convenience and not required to treat the resident's medical symptom. (A recliner could be considered a restraint if the resident is unable to operate the chair by themselves. If this is the case a nurse must be notified to get a doctor's order, for the resident to sit in a recliner.)

**Actions:**

1. Screening of Staff
    a. When selecting staff members or volunteers, give attention to prior work experience and references.
    b. Reference The State of Vermont Office of Professional Regulation for each Licensed Nursing Assistant prior to hiring. If not in good standing, do not hire.
    c. Reference the Board of Nursing for each licensed nurse prior to hiring. If the nurse is not in good standing with regard to abuse and neglect, do not hire.
    d. Do criminal background checks on all potential employees, volunteers, and students. Criminal records disqualify an individual from employment, volunteering, or training.

# abuse prohibition POLICY (continued)

2. Training of Staff

   a. Give each new staff member a clear description of his/her expected duties, responsibilities, and conditions of employment, including staff treatment of residents.

   b. Give each new staff member an orientation and annual training which shall include a review of abuse, neglect, and exploitation policies and the Resident's Bill of Rights.

   c. Provide education, through orientation and ongoing sessions, in the following areas: dealing with aggressive residents, recognizing and reporting abuse and neglect without fear of reprisal, recognition of signs of employee burnout and stress.

3. Prevention of Abuse

   a. Provide a safe living environment for residents through good maintenance and housekeeping practices and adequate equipment and buildings.

   b. Require assigned personnel to know the whereabouts of each resident at all times, and establish a procedure in the event a resident is reported missing.

   c. Assign sufficient staff on each shift to meet the needs of the residents; give staff access to information about specific resident care needs.

   d. Supervise staff in such a manner as to identify inappropriate behaviors such as rough handling of residents.

   e. Assess residents, create a service plan, and monitor to identify needs and behaviors that have the potential for leading to conflict or neglect: aggressive behaviors, wandering into other residents' rooms, communication disorders, and total dependency.

   f. Ensure that each employee understands that he or she is obliged to report knowledge of apparent abuse or neglect of a resident or misappropriation of a resident's property to his or her immediate supervisor.

   g. Ensure that each employee understands that individuals who fail to report a case of alleged abuse within 3 days of learning of the abuse may be subject to a monetary penalty

## abuse prohibition POLICY (continued)



imposed by the state.

4. Identification
   a. Evaluate the safety and well-being of the victim. Remove from immediate danger.
   b. Arrange immediate medical evaluation if indicated.
   c. Document the incident on an incident report form and on appropriate witness statements.
   d. Secure any physical evidence related to the incident for examination by the proper authorities.
   e. Investigate all incidents and injuries incurred by residents.

5. Investigation
   a. Inform the Staff RN or On-Call Nurse immediately of an incident of alleged or suspected abuse.
   b. The Staff RN or On-Call Nurse will conduct a thorough investigation of reports of alleged resident abuse or neglect to determine if the conduct of the individual is in violation of any standard of care. A written report will be completed and submitted to Adult Protective Services by a Staff RN within forty-eight hours of the reported incident. A copy of the written report with be given to the Administrator.
   c. Protect the resident or residents involved in a case of suspected abuse from potential additional harm during the investigation procedure. This includes, but is not limited to, suspension of the employee in question or changes in assignment.
   d. Obtain written statements from witnesses.
   e. The Staff RN or On-Call Nurse will notify the resident's family and/or responsible party and physician as soon as possible of the incident, and when completed, the results of the investigation.
   f. When a charge of resident abuse, neglect, or exploitation by an employee or volunteer is being investigated, the employee or volunteer should be placed on un-paid leave until the charge is fully investigated by Adult Protective Services. If the charge is substantiated, the employee/volunteer shall be terminated promptly.

## abuse prohibition POLICY (continued)

6. Reporting of Abuse
   a. Report any incident to the Staff RN and Administrator immediately.
   b. The Staff RN will report the incident to the State Regulatory Agency within 48 hours of the occurrence when:
      1) There is a specific written or verbal allegation of resident abuse, neglect, or misappropriation of resident property.
      2) There is a reasonable suspicion of resident abuse, neglect, or misappropriation of resident property.
      3) There is actual knowledge of resident abuse, neglect, or misappropriation of property.
   c. When appropriate, notify the following persons and agencies:
      - ✓ State licensing and certification agency
      - ✓ Law enforcement officials when there are allegations of criminal acts
      - ✓ Adult protective services
      - ✓ Ombudsman
      - ✓ The organization's legal counsel
      - ✓ The State Board of Nursing
      - ✓ Nurse Aide Registry
      - ✓ Others, as specified by state or local law
   d. Document all reports on the Resident Record.
7. Resident-to-Resident Abuse
   a. In the instance that a resident alleges abuse, sexual abuse, or if an injury requiring health care provider intervention results, or if there is a pattern of abusive behavior or if a resident is found to have been abused by another resident of the facility, a thorough investigation will be conducted by the Staff RN. If the instance requires health care provider intervention or if there is a pattern of abusive behavior, the Staff RN will report the incident to Adult Protective Services and to the Division of Licensing and Protection within 48 hours. A copy of this report will be given to the Administrator. Before reporting resident-to-resident

incidents, review the criteria for reporting. Isolated resident-to-resident abuse (hitting/slapping/name calling/ etc.) with no injury or injury that does not require health care provider intervention, or with no allegations of any abuse or if there is no pattern of abusive behavior do not require reporting. However, all resident-to-resident incidents must be recorded in the resident record and their families or legal representative must be notified.

b. Institute appropriate interventions such as counseling, psychiatric evaluation and treatment, behavior modification. When necessary, offer the resident to move to a different room. Any strategies developed to deal with the behaviors must be added to the care plan(s).

c. If the residents' behavior does not respond to the interventions and he or she continues to be a threat and a danger to others, discharge may be necessary.

8. Quality Assurance

a. Evaluate the following trends no less often than monthly, and more frequently when indicated:
   - ✓ Increasing injuries on the same resident
   - ✓ Multiple injuries in a specific location
   - ✓ Injuries in residents who are dependent
   - ✓ Increasing injuries of unknown origin
   - ✓ Increasing incidents involving same staff

b. When trends are identified, investigate further in order to determine if a problem exists.

c. All incidents, injury, and abuse data and investigations are to be documented by the nurse in the respective resident's progress notes.

**TIPS**

- Take immediate action — never delay action on a suspected incident.
- If a resident is hospitalized, stay in touch and consider sending flowers.
- Check your state and local law and regulations for specific requirements on abuse, neglect, and exploitation.